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Susan K. Rupp
CSAP's Western CAPT Program Assistant

Mary Anne Crane
CSAP's Western CAPT Administrative Assistant

Gretchen Casey
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CSAP's Western CAPT

Website: *http://www.westcapt.org*

Toll free: 888.734.7476

CONTENTS

Best Practices (continued)

FOREWORD

The Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies (CSAP's Western CAPT) is proud to provide *Best and Promising Practices for Substance Abuse Prevention* to the prevention community. The six regional CAPTs are funded by the Center for Substance Abuse Prevention to assist the prevention field in the application of science-based prevention strategies and programs. The *Best and Promising Practices for Substance Abuse Prevention* book is designed to assist in fulfilling this mission.

The CSAP's Western CAPT *Building a Successful Prevention Program* web site *(http://www.open.org/~westcapt)* forms the basis of the *Best and Promising Practices for Substance Abuse Prevention* book. Using criteria developed by researchers from a number of federal agencies, CSAP's Western CAPT has categorized prevention programs/strategies as "best," "promising," and "unproven." A variety of sources are used to identify prevention programs/strategies. Within these user-friendly pages and web site, prevention professionals search for scientifically-defensible prevention information across a number of variables; including risk factor, domain, age categories, ethnicity, and CSAP strategy. The *Building a Successful Prevention Program* "seven steps" process is also on this web site, allowing prevention providers to obtain state-of-the-art information in areas such as community readiness, needs assessment, best practices, and evaluation.

CSAP's Western CAPT produces this book primarily for those without Internet access, and certainly hopes the publication is found useful. Please note, however, the web site is updated on a regular basis and information within this book changes over time.

Please feel free to contact CSAP's Western CAPT office toll free at 888.734.7476 for information on other CSAP's Western CAPT products and services.

CSAP's Western CAPT extends special thanks to Kristen Reed Gabrielsen, CSAP's Western CAPT Associate Director; Susan K. Rupp, CSAP's Western CAPT Program Assistant; Mary Anne Crane, CSAP's Western CAPT Administrative Assistant; and Gretchen Casey, CSAP's Western CAPT Special Projects Coordinator for producing this document.

Julie Hogan, Ph.D., Director
CSAP's Western CAPT

GUIDING PRINCIPLES, BEST PRACTICES AND PROMISING PRACTICES

What are guiding principles and best practices?

Best practices are those strategies, activities, or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying substance abuse.

Guiding principles are recommendations on how to create effective prevention programs. When a community already has a prevention program or strategy in place, the guiding principles can be used to gauge the program's potential effectiveness. They can also be used to design an innovative program/strategy when none of the best practices are appropriate to the community's needs.

Before you select a best practice or apply the guiding principles, your community must conduct an assessment (risk assessment) to identify the risk and protective factors that need to be addressed in your community. Once you have identified which risk and protective factor(s) to address through your assessment, you can use the information in this book to select the best practice(s) and/or guiding principles to address your community's needs.

Definition of "best practice"

In this web site "best practices" are those strategies and programs that are deemed research-based by scientists and researchers by the following agencies:

National Institute on Drug Abuse (NIDA)

Center for Substance Abuse Prevention (CSAP)

National Center for the Advancement of Prevention (NCAP)

Office of Juvenile Justice and Delinquency Prevention (OJJDP)

Centers for Disease Control and Prevention (CDC)

These are strategies and programs that have been shown through substantial research and evaluation to be effective at preventing and/or delaying substance abuse. If you are familiar with the rating scale presented in the document, "Science-Based Practices in Substance Abuse Prevention: A Guide" prepared by P.J. Brounstein, J.M. Zweig, and S.E. Gardner, the best practices in this web site would fall into the categories of types 5, 4, and some 3.

Please Note: Each best practice has not been labeled either 3, 4, or 5. The authors of the document did not label each program with a number of 3, 4, or 5. Therefore, this information does not exist.

We have also included a category called "Promising Practices" in areas of the web site where there are few programs that have enough outcome data (or that have been sufficiently evaluated) to be deemed best practices.

Definition of "promising practices"

Promising practices are programs and strategies that have some quantitative data showing positive outcomes in delaying substance abuse over a period of time, but do not have enough research or replication to support generalizable outcomes. These practices would fall into the rating scale (mentioned above) of types 1, 2 and some 3.

Submitting your program for review

If you wish to have your program reviewed to be included as a best or promising practice, visit the following web site and click on "registry": *http://www.preventionsystem.org*

Note: No single best practice will be successful at preventing substance abuse in your community. To be as comprehensive as possible, best practices addressing prevention strategies (CSAP strategies) in all areas of your community (family, school, individual, peer, society/community) should be implemented. Remember: There is no single "magic" program in prevention!

PREVENTION PRINCIPLES FOR CHILDREN AND ADOLESCENTS

(Excerpt from *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide by the National Institute on Drug Abuse*, 1997, pages i-ii)

The following principles can be applied to either existing programs to assess their potential effectiveness or used when designing innovative programs/strategies:

- Prevention programs should be designed to enhance protective factors and move toward reversing or reducing known risk factors.
- Prevention programs should target all forms of drug abuse, including the use of tobacco, alcohol, marijuana, and inhalants.
- Prevention programs should include skills to resist drugs when offered, strengthen personal commitments against drug use, and increase social competency (e.g., in communications, peer relationships, self-efficacy, and assertiveness) in conjunction with reinforcement of attitudes against drug use.
- Prevention programs for adolescents should include interactive methods, such as peer discussion groups, rather than didactic teaching techniques alone.
- Prevention programs should include a parents' or caregivers' component that reinforces what the children are learning - such as facts about drugs and their harmful effects - and that opens opportunities for family discussions about use of legal and illegal substances and family policies about their use.
- Prevention programs should be long-term, over the school career with repeat interventions to reinforce the original prevention goals. For example, school-based efforts directed at elementary and middle school students should include booster sessions to help with critical transitions from middle to high school.
- Family-focused prevention efforts have a greater impact than strategies that focus on parents only or children only.
- Community programs that include media campaigns and policy changes, such as new regulations that restrict access to alcohol, tobacco, or other drugs, are more effective when they are accompanied by school and family interventions.
- Community programs need to strengthen norms against drug use in all drug abuse prevention settings, including the family, the school and the community.
- Schools offer opportunities to reach all populations and also serve as important settings for specific sub-populations at risk for drug abuse, such as children with behavior problems or learning disabilities and those who are potential dropouts.
- Prevention programming should be adapted to address the specific nature of the drug abuse problem in the local community.
- The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.
- Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive.
- Effective prevention programs are cost-effective. For every dollar spent on drug use prevention, communities can save 4 to 5 dollars in costs for drug abuse treatment and counseling.

[To order a free copy of *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide by the National Institute on Drug Abuse* (1997) contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI):

Web site: *http://ncadi.samhsa.gov*

Phone: 800.729.6686

and request publication order no. "PHD 734"]

INTRODUCTION

Best Practices and Promising Practices Summaries

The following pages contain summaries of best practices and promising practices in alphabetical order. Included in each summary is a description of the program or strategy, the risk factors and protective factors it primarily addresses, the CSAP strategies used (explained in Appendix B), the Institute of Medicine classification (see Appendix H), recommendations on how to evaluate the program/strategy, research conclusions, cost, special considerations and contact information. In the appendices, the programs and strategies are cross-indexed according to these categories. Some program developers did not submit complete information. Consequently, please contact the developers directly for additional program information.

The programs and strategies listed in this book and on the related CSAP's Western CAPT web site (*www.open.org/~westcapt*) are examples of scientifically-defensible prevention efforts. While CSAP's Western CAPT does review prevention literature and periodically update the information, there are likely to be other proven practices that are not listed. Inclusion of a strategy or program in this document does not imply endorsement by the CSAP's Western CAPT nor by the Center for Substance Abuse Prevention.

The information in this volume is continually updated on the CSAP's Western CAPT web site. For information about new strategies or changes to this volume, please visit the web site at *www.open.org/~westcapt*, or call CSAP's Western CAPT staff toll free at 888.734.7476.

If you wish to have your program reviewed to be included as a best or promising practice, visit the National Prevention System web site and click on "registry,"

Web site: *http://www.preventionsystem.org*

Best Practices

BEST PRACTICE: Across Ages

(CSAP Demonstration Grant #2779)

Description of Best Practice

(Excerpt from "Understanding Substance Abuse Prevention — Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished document.)

The Across Ages program included three components: elders mentoring youth, youth performing community service, and teacher training. The core of the program, mentoring, involved older adults (55+ years old) spending a minimum of four hours each week (two 2-hour sessions) with high-risk students assigned to them. Mentors met with students all year long, not just during the school year. Mentors were carefully recruited, screened, trained, and matched with one or two high-risk youth. Mentors were also carefully supervised by project staff, who also provided support.

Mentoring activities included: tutoring, assistance with school projects, recreational activities, attending cultural or sporting events, performing community service, or just time spent nurturing. Most of these activities took place out of the school setting.

The second focus of Across Ages was student service: Here, students performed community service by making biweekly visits of about an hour to institutionalized frail elderly. This activity, designed to break down age-related stereotypes among youth, also served to reinforce feelings of competence, teach self-confidence, improve self-concept, and instill a sense of social responsibility.

The third component of Across Ages was teacher training: Teachers were trained to administer to sixth graders the Social Problem Solving and Substance Abuse Prevention modules of the Positive Youth Development Curriculum (PYDC). The PYDC modules involve 26 lessons, taught at least once a week for about an hour, focusing on stress management, self-esteem, problem solving, substance and health information, as well as social networks and peer resistance skills.

Lastly, Across Ages offered a series of activities that provided the opportunity for positive interaction among parents, students, and mentors: meals, transportation, and incentives were offered to participating parents.

Taken together, these data demonstrate:

- the effectiveness of matching youth with older adults serving as mentors in improving pro-social values,
- increasing knowledge of the consequences of substance use, and
- engendering resilience to help youth avoid later substance use by teaching them appropriate resistance behaviors.

Risk Factors Addressed

Low commitment to school

Protective Factors Addressed

Bonding: School and people with healthy beliefs and clear standards
Healthy beliefs and clear standards
Skills: Resistance skills
Opportunities: Community service

CSAP Strategies

Information dissemination
Education
Alternatives

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- 6th Grade
- African American
- Asian
- Hispanic
- Caucasian

Evaluating This Best Practice

This best practice comes with an evaluation tool, Across Ages Evaluation Protocol, that can be used when implementing this strategy.

Evaluation Tool Cost: $25.

The following are suggested areas to assess when implementing this practice:

- Assess increased knowledge of community service and more positive attitudes toward people and the future
- Assess number of days absent from school and attitudes toward school

Research Conclusions

(Excerpt from "Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished document.)

The data (gathered from this demonstration) demonstrate the effectiveness of matching youth with older adults serving as mentors in improving:

- Pro-social values
- Increasing knowledge of the consequences of substance use
- Engendering resilience to help youth avoid later substance use by teaching them appropriate resistance behaviors.

Costs as of May 2001 (Subject to Change)

Training Time is two days.

Training Costs: $1000 per day, plus travel and per diem.

- This model is for program replication; it is not a train-the-trainers model.
- Providers may become educated about the model in a shorter training that is not sufficient for implementation.
- Easily understood, Across Ages is more complex in implementation than it appears.

Technical Assistance Costs:
On-site, $500 per day plus travel and per diem; telephone, $30 per hour.

Strategy Implementation:
$1,500 to $2,000 per child for 12 months. These figures include the following:

At least one full-time staff member, mentor stipends or activity fund, cost of covering background checks for mentors, curriculum materials for life skills, Across Ages program development manual and mentor training materials, materials and activity costs for mentor-youth activities, community service activities and family events, transportation, office costs.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Partnerships and collaboration with community organizations
- Cultural issues around mentoring
- Access to older adults in the community who will serve as mentors
- Community site for program activities
- Target population of youth from a specific location
- Awareness of ageism on the part of project staff, families and youth

Contact Information

For more information on this program, visit web site:
http://modelprograms.samhsa.gov

For training, technical assistance, and materials, visit the following web site:
http://www.temple.edu/CIL/

Or contact:

Andrea Taylor, Ph.D.
Temple University
Center for Intergenerational Learning
1601 N. Broad Street, USB 206
Philadelphia, PA 19122

E-mail: andreat46@aol.com

Phone: 215.204.6708

Fax: 215.204.6733

BEST PRACTICE: Adolescent Alcohol Prevention Trial

(Donaldson et al)

Description of Best Practice

The Adolescent Alcohol Prevention Trial is not replicable. See below for details.

AAPT was a research project conducted by William Hansen. It included a universal classroom program designed for fifth grade students, with booster sessions conducted in the seventh grade. It included two primary strategies: resistance skills training designed to give children the social and behavioral skills they need to refuse explicit drug offers, and normative education specifically designed to combat the influences of passive social pressures and social modeling effects. It focused on correcting erroneous perceptions about the prevalence and acceptability of substance use and on establishing conservative group norms.

AAPT was a research project, not a program. Consequently, it is not possible to replicate AAPT. However, William Hansen took the part of AAPT that was identified as effective, and created the program, All Stars. The All Stars Program is replicable, with training and materials available.

Risk Factors Addressed

Favorable attitudes toward drug use
Friends who use

Protective Factors Addressed

Healthy beliefs and clear standards
Skills: Social and behavioral

CSAP Strategies

Information dissemination, education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Fifth and seventh grades

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess decreased use of alcohol, tobacco and marijuana
- Assess change in favorable attitudes toward drug use
- Assess social and behavioral skills gained

Research Conclusions

(Excerpt from *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide*, National Institute on Drug Abuse, 1997, page 22.)

- In the research design, the students received either information about consequences of drug use only, resistance skills only, normative education only, or resistance skills training in combination with normative education.
- Results showed that the combination of resistance skills training and normative education prevented drug use; resistance skills training alone was not sufficient.

Costs and Special Considerations

Not applicable

Contact Information

AAPT is not replicable. Please review All Stars for the program that was developed from AAPT.

For questions about AAPT, contact:

William B. Hansen, Ph.D.
7017 Albert Pick Road, Suite D
Greensboro, NC 27409

E-mail: billhansen@tanglewood.net
Phone: 800.826.4539
Fax: 336.662.0099

BEST PRACTICE: Adolescent Transitions Program

(Dishion et al)

Description of Best Practice

(Excerpt from *Preventing Drug Use Among Children and Adolescents*, National Institute on Drug Abuse, 1997, pages 28-29.)

The ATP is a school-based program that focuses on parenting practices and integrates the universal, selective, and indicated approaches for middle and junior high school interventions within a comprehensive framework. The universal level of the ATP strategy, directed to the parents of all students in a school, establishes a Family Resource Room. The goal, through collaboration with the school staff, is to engage parents, establish norms for parenting practices, and disseminate information about risks for problem behavior and substance use. The videotape "Parenting in the Teenage Years" helps parents identify observable risk factors and focuses on the use of effective and ineffective family management skills, including positive reinforcement, monitoring, limit-setting, and relationship skills to facilitate evaluation of levels and areas of risk.

The selective level of intervention, the Family Check-Up, offers family assessment and professional support to identify those families at risk for problem behavior and substance use. The indicated level, the Parent Focus curriculum, provides direct professional support to parents for making the changes indicated by the Family Check-Up. Services may include behavioral family therapy, parenting groups, or case management services. Following this tiered strategy, a family in the indicated parenting intervention would have participated in a Family Check-up and received information from the school's Family Resource Room about risk factors for early substance use and parenting practices that reduce the risk of drug use for their children.

Risk Factors Addressed

Family conflict
Family management problems

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination
Education

Type of Strategy

Universal
Selective
Indicated

Populations Appropriate for This Best Practice

Middle and junior high school youth

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Determine whether family management skills were enhanced
- Determine decreases in parental stress

Research Conclusions

(Excerpt from *Preventing Drug Use Among Children and Adolescents*, National Institute on Drug Abuse, 1997, page 29.)

This program is based on a series of intervention trials which comprise the Parent Focus curriculum and other intervention strategies, including working with high-risk teens in groups (Teen Focus curriculum) and directed strategies involving videotapes and newsletters. The findings from these studies indicate that parent interventions are needed for youth at high risk to reduce escalation of drug use, and repeated booster sessions are needed throughout the period of risk. These interventions were especially important because it was found that youth at high risk should not be places together in groups because it can worsen problem behaviors including those related to school and drug use.

Costs and Special Considerations

Please inquire of the contacts below.

Contact Information

For training and technical assistance contact:
Kathryn Kavanagh, Ph.D.
Project Alliance
2738 NE Broadway
Portland, OR 97232
E-mail: katek@darkwing.uoregon.edu
Phone: 503.282.3662
Fax: 503.282.3808

For an informational packet only, contact:
Ann Simas
Publications
Child and Family Center
Department of Psychology
University of Oregon
195 West 12th Avenue
Eugene, OR 97401-3408
E-mail: asimas@darkwing.uoregon.edu
Phone: 541.346.1983
Fax: 541.346.4858

For free preview of *Adolescent Transitions*, contact:
Independent Video Services
Phone: 800.678.3455

BEST PRACTICE: All Stars Program

Description of Best Practice

(Information provided by Tanglewood Research, May 2001.)

The All Stars Program comes in two formats: Middle School Classroom Format and Community-Based Format.

Each format:

- Reinforces the belief that risky behaviors are not normal or acceptable by the adolescent's peer group
- Cultivates the belief that risky behaviors do not fit with the youth's personal ideals and future aspirations
- Creates strong voluntary personal and public commitments to not participate in risky behaviors
- Strengthens relationships between the adolescent, social institutions, and significant adults
- Helps parent to listen to their children, communicate clear no-use expectations about alcohol and other drugs, and support their children in working towards positive life goals

Middle School Classroom Format

- Targets the first year of middle or junior high school
- For use by classroom teachers, law enforcement officials, prevention specialists, and school counselors
- Includes thirteen 45-minute interactive classroom sessions, one-on-one meetings and small group discussions, a parent component, and a public celebration at the end
- Provides a community relations and promotion package

Community-Based Format

- Targets youth, ages 11 to 14, in already-established groups within community settings (e.g. churches, after school programs, community centers, boys and girls clubs)
- For use by the adult leaders (professional or volunteer) of the youth group/setting
- Includes nine, one-hour interactive group sessions, one-on-one meetings, small group discussions, a parent component, and a public celebration at the end
- Provides a community relations and promotion package
- Provides a method for continuously integrating prevention

Risk Factors Addressed

Favorable attitudes toward drug use

Protective Factors Addressed

Bonding with positive institutions
Healthy beliefs and clear standards

CSAP Strategy

Information dissemination
Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Early adolescents between the ages of 10 and 15

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
The survey instrument is free. Please call the contact phone number regarding analysis costs. Analysis will be free soon, upon development of a web site for completing online evaluation.

The following are suggested areas to assess when implementing this practice:

- Assess participants' commitment to avoid risky behaviors
- Assess participants' bonding to school, the group, and to another adult
- Assess participants' normative beliefs
- Assess participants' perception that risky behaviors would interfere with their future goals and ideals

Research Conclusions

(Excerpt from All Stars web site, *www.tanglewood.net*)

- All Stars students' commitment to avoid high-risk behavior significantly improved
- All Stars students' increased their bonding to school
- All Stars students' viewed high-risk behavior to be less accepted
- All Stars students' continued to view their lifestyle to be incongruent with high-risk behaviors

Costs as of December 2001 (Subject to Change)

Training Time: Two days

Training Costs:

- Option 1 – Individual attending a scheduled training:
  $250 per person plus travel expenses
  $100 per person for facilitator curriculum
- Option 2 – Group training (up to 20 participants):
  $3,000 plus travel expenses for group training of 12 or more
  $100 per person for facilitator curriculum

Strategy Implementation:
Please visit web site: *http://www.tanglewood.net* for current prices.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Both program formats are ideally designed for either 6th or 7th grades with a booster program one year later.
- Both program formats target not just substance use, but also early sexual activity and violence.
- An elementary program for 4th and 5th grades is currently under development (ALL STARS Junior) as is a high school program for use in high school health courses (ALL STARS Senior).

Contact Information

For more information, visit web site:
http://www.tanglewood.net

For technical assistance, training, or more information, contact:

Kathleen Nelson-Simley
Tanglewood Research, Inc.
PO Box 5512
Lincoln, NE 68505
E-mail kathleensimley@alltel.net
Phone: 800.822.7148
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Phone: 800.826.4539
Fax: 336.662.0099

BEST PRACTICE: Athletes Training and Learning to Avoid Steroids: The ATLAS Program

(Goldberg et al)

Description of Best Practice

(Excerpt from *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide*, National Institute on Drug Abuse, 1997, pages 23-24, and modified by Linn Goldberg of ATLAS in December 2001.)

ATLAS is a multi-component universal program for male high school athletes, designed to reduce risk factors for use of anabolic steroids and other drugs while providing healthy sports nutrition and strength-training alternatives to illicit use of athletic-enhancing substances. Coaches and peer teammates facilitate curriculum delivery with scripted manuals in small cooperative learning groups, taking advantage of an influential coaching staff, and the team atmosphere where peers share common goals.

The seven 45-minute classroom sessions and seven physical training periods involve role-playing, student-created campaigns, and educational games. Instructional aids include pocket-sized food and exercise guides and easy-to-follow student workbooks. Parents are involved with parent-student homework and with the booklet "Family Guide to Sports Nutrition."

The program features learning about anabolic steroids and other drugs, skills to resist drug offers, team ethics and drug-free commitment, drug use norms, vulnerability to drug effects, debunking media images that promote substance abuse, parent, coach, and team intolerance of drug use, and goal-setting for sports nutrition and exercise. Weight-lifting instruction at the school promotes safe training practices, reduces the influence of commercial gyms (where anabolic steroids and other drugs are more available), and highlights curriculum components.

Risk Factors Addressed

Favorable attitudes toward drug use
Friends who use
Community norms favorable toward drug use
Parental attitudes favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Information dissemination
Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Male high school athletes

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
The evaluation tool is free upon request; the cost of analysis varies according to type of analysis.

The following are suggested areas to assess when implementing this practice:

- Assess understanding of harmful effects of anabolic steroids and other drugs
- Assess belief in personal vulnerability to the adverse effects of anabolic steroids
- Assess belief that their parents and coaches are intolerant of drug use
- Assess refusal skills
- Assess belief in steroid-promoting images

Research Conclusions

(Excerpt from P*reventing Drug Use Among Children and Adolescents: A Research-Based Guide*, National Institute on Drug Abuse, 1997, page 24.)

Student athletes receiving the ATLAS program report: better understanding of the effects of anabolic steroids and other drugs, greater belief in personal vulnerability to the adverse effects of anabolic steroids, and more certainty that their parents and coaches are intolerant of drug use. In addition: improved drug refusal skills, less belief in steroid-promoting media images, more confidence in personal ability to build muscle and strength without steroids, greater self-esteem, and less desire to use anabolic steroids were found among members of the intervention group.

Importantly, these high school athletes continued to resist the temptation to use anabolic steroids and maintained better nutrition and exercise behaviors one year after the intervention. The program contains four booster sessions for each subsequent year of high school.

A more recently published study* also showed positive results including: Significant reductions in new use of alcohol and illicit drugs (marijuana, amphetamines, narcotics); 50% reduction in new use of anabolic steroids; significant reductions in use of "athletic" supplements; 24% reduction in drinking and driving occurrences; improved nutrition behaviors; improved exercise self-efficacy; greater belief in the personal vulnerability to the adverse effects of anabolic steroids; greater belief in one's personal athletic competence.

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*Goldberg L., MacKinnon D.P., Elliot D.L., Moe E.L., Carke G., Cheong J.W. The adolescents training and learning to avoid steroids program: Preventing drug use and promoting health behaviors. *Arch Pediatr Adolesc Med.* Vol 154: 332-338, 2000.

Costs as of December 2001 (Subject to Change)

Training is optional for this program.

Training Time: Six to eight hours

Training Costs: $1,750 plus expenses for two persons.

Note: Training is for teachers and coaches only. One large room is needed to train teachers and coaches. Two rooms are necessary if coaches and peer leaders are trained.

Strategy Implementation Cost:
$149.95 (Program Cost, includes 10 Athletes' Packs)

$39.95 (3-booklet Athletes' Pack for 10 packs) Possible additional photocopying costs for peer leaders.

This translates into a cost of $510 for 100 participants, plus photocopying costs of about $1 - $2 per peer leader.

Special Considerations

Please consider the following before selecting this strategy for your community:

- See training accommodation requirements above
- The best setting is the team environment

Contact Information

For materials, contact:

Sunburst Communications, Inc.
Phone: 800.431.1934 or
800.338.3457

For training, technical assistance, or more information on this best practice, contact:

Linn Goldberg, M.D.
Division of Health Promotion and Sports Medicine, CR110
Oregon Health Sciences University
3181 SW Sam Jackson Park Road
Portland, OR 97201-3098
E-mail: goldberl@ohsu.edu
Phone: 503.494.6559
Fax: 503.494.1310

BEST PRACTICE: Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions

Description of Best Practice

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, *http://www.Colorado.edu/cspv/blueprints/promise/preventTreat.htm*)

The Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions seek to improve children's psychological well-being and social task performance. The former focuses on strengthening reading achievement to reduce the risk of depression later in life, while the latter aims to decrease early aggressive and shy behaviors to prevent later criminality. Both are implemented when children are in early elementary grades in order to provide students with the skills they need to respond to later, possibly negative, life experiences and societal influences.

The Good Behavior Game is primarily a behavior modification program that involves students and teachers. It improves teachers' abilities to define tasks, set rules, and discipline students, and allows students to work in teams in which each individual is responsible to the rest of the group.

Before the time begins, teachers clearly specify those disruptive behaviors (e.g. verbal and physical disruptions, noncompliance, etc.) which, if displayed, will result in a team's receiving a checkmark on the board. By the end of the game, teams that have not exceeded the maximum number of marks are rewarded, while teams that exceed this standard receive no rewards. Eventually, the teacher begins the game with no warning and at different periods during the day so that students are always monitoring their behavior and conforming to expectations.

The Mastery Learning intervention improves reading skills in order to combat learning problems and subsequent risk for depression. Like the Good Behavior Game, it utilizes a group-based approach in which students are assigned reading units but cannot advance until a majority of the class has mastered the previous set of learning objects.

Risk Factors Addressed

Academic failure
Early antisocial behavior

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Education

Type of Strategy

Universal or Selective

Populations Appropriate For This Practice

- Early elementary school children
- Children demonstrating early high-risk behavior

Evaluating This Practice

The following are suggestions of areas you may want to assess if you implement this practice:

- Assess aggressive behaviors
- Assess school achievement, including reading achievement

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, web site: *http://www.Colorado.edu/cspv/blueprints/promise/preventTreat.htm*)

Evaluations of both programs have demonstrated beneficial effects for children at the end of first grade, while an evaluation of the Good Behavior Game has shown positive outcomes at grade six for males displaying early aggressive behavior.

At the end of first grade, GBG students, compared to a control group, had:

- Less aggressive and shy behaviors according to teachers, and
- Better peer nominations of aggressive behavior.

At the end of first grade, ML students, compared to a control group, showed:

- Increases in reading achievement.

At the end of sixth grade, GBG students, compared to a control group, demonstrated:

- Decreases in levels of aggression for males who were rated highest for aggression in the first grade.

For evaluation results see:
Kellam, S.G., Rebok, G.W., Ialongo, N., & Mayer, L.S. (1994). The course and malleability of aggressive behavior from early first grade into middle school: Results of a developmental epidemiologically-based preventive trial. *Journal of Child Psychology and Psychiatry*, 35 (2) 259-282. VP-2501.

Contact Information

For more information, contact web site:

Jeanne Poduska, Deputy Director
AIR Center for Integrating Education and Prevention Research in Schools
1000 Thomas Jefferson Street
Washington, DC 20007
Phone: 202.944.5417

Dr. Sheppard G. Kellam
E-mail: kellam@air.org
Phone: 202.944.5418
Web site: *http://www.bpp.jhsph.jhu.edu*

BEST PRACTICE: Blood Alcohol Concentration Laws

Description of Best Practice

(Excerpt from *Alcohol Alert*, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, p. 1, PH 370.)

States which have lowered the blood alcohol concentration (BAC) limit from 0.10 to 0.08 have seen a reduction in alcohol-related fatal motor vehicle crashes.

Risk Factors Addressed

Community laws and norms favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Not specific

Evaluating This Best Practice

The following suggestion is an area you may want to assess if you implement this best practice:

- Assess decline in proportion of fatal crashes involving fatally injured drivers whose BAC's were 0.08 or higher.

Research Conclusions

(Excerpt from *Alcohol Alert*, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, p. 1, PH 370.)

- One study found that states with the reduced limit experienced a 16 percent decline in the proportion of fatal crashes involving fatally injured drivers whose BAC's were 0.08 percent or higher, compared with nearby states that did not reduce their BAC limit.
- In a separate analysis, this study found that states that lowered their BAC limit also experienced an 18 percent decline in the proportion of fatal crashes involving fatally injured drivers whose BAC's were 0.15 or higher, relative to comparison states.

Contact Information

You can also find the document *Save Lives: Recommendation to Reduce Underage Access to Alcohol* on Join Together's web site, *www.jointogether.org*, in the resources section/publications.

For information on how to enact a policy change regarding BAC laws, obtain a free hard copy of *How to Change Local Policies to Prevent Substance Abuse* from:

Join Together
441 Stuart Street, 7th Floor
Boston, MA 02116
Phone: 617.437.1500
Fax: 617.437.9394

BEST PRACTICE: Brief Strategic Family Therapy

Description of Best Practice

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html*)

Brief Strategic Family Therapy (BSFT) is a family-based intervention aimed at preventing and treating child and adolescent (ages 8-17) behavior problems including mild substance abuse. BSFT was developed at the Center for Family Studies, a division of the University of Miami Medical School's Department of Psychiatry and Behavioral Sciences, in 1975, and has since been tested and refined in clinical studies.

BSFT is based on the fundamental assumption that adaptive family interactions can play a pivotal role in protecting children from negative influences, and that maladaptive family interactions can contribute to the evolution of behavior problems and consequently is a primary target for intervention. The goal of BSFT is to improve the youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.

Therapy is tailored to target the particular problem interactions and behaviors in each client family. Therapists seek to change maladaptive family interaction patterns by coaching family interactions as they occur in session to create the opportunity for new, more functional interactions to emerge. Major techniques used are joining (engaging and entering the family system), diagnosing (identifying maladaptive interactions and family strengths), and restructuring (transforming maladaptive interactions). BSFT has been tailored to work with inner city, minority families, particularly African American and Hispanic families, and therapists are trained to assess and facilitate healthy family interactions based on cultural norms of the family being helped.

BSFT is a short-term, problem-focused intervention. A typical session lasts 60 to 90 minutes. The average length of treatment is approximately 12-15 sessions over three months. For more severe cases, such as substance abusing adolescents, the average number of sessions and length of treatment may be doubled. Treatment can take place in the office or home/community settings.

Note: Some funding agencies may classify this as an "intervention" or "treatment" program and consequently, may not fund it with prevention dollars.

Risk Factors Addressed

Family management problems
Family conflict

Protective Factors Addressed

Bonding – Family
CSAP Strategy
Education

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

- Inner city, minority families, particularly African American and Hispanic families
- 8- to 17-year-old youth who are displaying or are at risk for developing behavior problems, including substance abuse

Evaluating This Best Practice

This best practice can come with an evaluation tool that can be used when implementing this strategy. Tools can be tailored to the needs of each program.

Evaluation Tool Cost

The cost of the evaluation tool varies. Please contact Carleen Robinson (see below) for more information.

The following are suggestions of areas you may want to assess if you implement this best practice:

- Assess change in family management skills
- Assess rate of behavior problems of youth participants
- Assess rate of alcohol, tobacco, and other drug use by youth participants
- Assess the level of conflict between family members

Research Conclusions

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html*)

BSFT has been rigorously evaluated in a number of studies with experimental designs. The approaches have been found to be effective in improving youth behavior, reducing recidivism among youthful offenders, and in improving family relationships.

Costs as of January 2002 (Subject to Change)

Training Time and Cost:
The Center for Family Studies can customize a training package to meet the needs of a particular agency depending on agency size, level of clinical staff experience, and treatment population. Standard training packages include the following:

- Package I – Overview of the model consists of one 3-day beginners' level workshop for up to 30 attendees. Fee: $6,000
- Package II – Intensive intermediate level for up to 30 attendees consists of two 3-day workshops including clinical case consultation. Fee: $12,000
- Package III – Intensive intermediate level for up to 15 attendees consists of three 3-day workshops including clinical case consultation. Fee: $16,000

- Package IV – Certification in BSFT for up to five candidates per agency that consists of: Biweekly review of 5 videotapes of BSFT family therapy, biweekly 2-hour group telephone consultation/feedback, and one 2-day advanced workshop. Fee: $17,650 (Requisite: Successful completion of Package III – Intensive Intermediate.)

Note: Packages III and IV constitute certification.

Implementation Cost:
Staff requirements for implementing BSFT include: BSFT therapists and a clinical supervisor. In mild to moderate cases we have found that a reasonable clinical load for a full-time therapist is 20 active cases.

BSFT therapists typically have master's level training in mental health, social work or counseling, and at least three years of supervised clinical experience. In addition to skills specific to BSFT, therapist must possess the clinical skills of empathy, timing, ability to provide support and validation, ability to establish working alliances with individuals and families, enthusiasm, and optimism. Cultural competence to work with minority populations is also crucial.

Other program implementation costs include office space, transportation costs (for therapists doing home/community visits or for families to attend therapy in the office). It is recommended that therapy sessions be either video or audio taped for clinical supervision.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

- Need to have staff who can learn the model well and who follow through, in order to ensure the effectiveness of the program.

Contact Information

For more information on this program, visit web site: *http://www.ncjrs.org/html/ojjdp/jjbul2000_04_3/contents.html*

For technical assistance, training and materials:

Carleen Robinson Batista
University of Miami
Center for Family Studies
1425 NW 10th Avenue, 3rd Floor
Miami, FL 33136

E-mail: crobins2@med.miami.edu

Phone: 305.243.4592

Fax: 305.243.5577

Web site: *http://www.cfs.med.miami.edu*

BEST PRACTICE: Bry's Behavioral Monitoring and Reinforcement Program

Description of Best Practice

(Excerpt taken from information provided by Brenna H. Bry, Graduate School of Applied and Professional Psychology, Rutgers University, Piscataway, NJ: "Program Fact Sheet.")

Bry's Behavioral Monitoring and Reinforcement Program is a school-based, early intervention program borne from earlier work on behavior modification and teaching thinking skills.

The program targets seventh and eighth graders and includes the following components:

Collecting Up-To-Date Information about Each Student's Actions
Experimenters enter the school each week, record the daily attendance and discipline referrals of program participants, and complete individual "Weekly Report Cards" for each student based on information gained in teacher interviews. During these interviews, teachers are asked whether students had done the following things during the previous week:

(a) came to class on time
(b) brought materials needed for classwork
(c) done the classwork
(d) exhibited satisfactory behavior, and
(e) done homework, if it was assigned

Providing Systematic Feedback
Experimenters meet weekly with students in small groups (five to seven students). The "Weekly Report Cards" are distributed and discussed individually. Positive teacher ratings are praised and negative ratings lead to discussions of what the student can do to improve that teacher's impression of his or her behavior. Parents are often contacted throughout the program, by letter, telephone, and home visits to inform them about their child's progress.

Attaching Value to the Student's Actions
Students receive a point for every day that they come to school, arrive on time, and receive no disciplinary action, and for each positive rating they receive on their "Weekly Report Cards." At the end of meetings, students are also given points for obeying specific meeting rules, such as not laughing at or criticizing other people, not touching other people or their possessions, and not talking while others are talking. Students accumulate their points during the year to earn an extra school trip of their own choosing.

Following the two-year intervention, students are invited to biweekly booster sessions, which follow the same format as the original intervention.

Risk Factors Addressed

Academic failure
Antisocial behavior

Protective Factors Addressed

None specifically identified

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Seventh and eighth grade students

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy. Student report cards with grades and attendance can be used as the outcome measurements.

The following are suggested areas to assess when implementing this practice:

- Assess participants' grades and attendance
- Assess number of problem behaviors of participants at school
- Assess level of criminal behavior and substance abuse by participants

Research Conclusions

(Excerpt taken from information provided by Brenna H. Bry, Graduate School of Applied and Professional Psychology, Rutgers University, Piscataway, NJ: "Program Fact Sheet.")

Forty 7th graders were selected from a class of 555 students in a large, urban, racially mixed junior high school. Selected students met at least two of the three following criteria: (1) low academic motivation, (2) family problems, and (3) frequent or serious discipline referrals. Students were randomly assigned to either a treatment or control group. Students' tardiness, class preparedness, class performance, classroom behavior, school attendance, and disciplinary referrals were monitored weekly for two years.

For the one-year follow-up study, 30 students from an urban school system plus 36 students from a suburban school system were evaluated. Information was collected from school records and through structured, self-reported interviews with study participants. The interview included questions about employment, alcohol use, drug use, and criminal behavior. Fewer than 50 percent of the intervention subjects attended the booster sessions offered during this 12-month period.

Sixty students from the one-year follow-up study participated in the five-year follow-up study. Arrest records were used to assess participant involvement with the criminal justice system. Compared to the control group, experimental students had significantly better grades and attendance at the end of the program. However, these positive effects did not appear until the students had been in the program for two years.

In the year after the intervention ended, experimental students displayed significantly fewer problem behaviors at school than did controls. Eighteen months following the intervention, experimental students reported significantly less substance abuse and criminal behavior. Five years after the program ended, experimental youth were 66 percent less likely to have a juvenile record than were controls.

Costs as of December 2001 (Subject to Change)

Training and technical assistance is not required.

Training Time:
One eight-hour day workshop for 30 participants.

On-going training during the year for 30 participants. The training occurs as 20-minute individual consultations, once every six weeks, by mail, telephone or e-mail.

Training Costs:
$1,600 plus travel expenses

$10,500 for on-going training during the year for 30 participants ($175/hour)

$1,800 for materials for 30 participants

The Early Secondary Intervention Program (ESIP) manual is available at no cost.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Implementers should like students who are at higher risk.
- Implementers need to have two hours a week during the school day to implement the program. They can either be school employees or come into the school from the community for two hours/week.

Contact Information

The Early Secondary Intervention Program (ESIP) manual is available at no cost from Dr. Brenna Bry.

For training, technical assistance, and materials contact:

Brenna Hafer Bry, Ph.D.
Graduate School of Applied and Professional Psychology
Rutgers University
152 Frelinghuysen Road
Piscataway, NJ 08854-8085

E-mail: bbry@rci.rutgers.edu

Phone: 732.445.2189

Fax: 732.445.4888

BEST PRACTICE: CASASTART

Description of Best Practice

(Excerpt from "Impact of the Children at Risk Program – Comprehensive Final Report II;" and CASASTART (Striving Together to Achieve Rewarding Tomorrows) – A Program of The National Center on Addiction and Substance Abuse at Columbia University. Both are available from The National Center on Addiction and Substance Abuse at Columbia University, New York, NY.)

CASASTART is the second generation of the Children at Risk (CAR) program, a research/demonstration model program that was tested in six cities throughout the United States (Austin, TX; Bridgeport, CT; Memphis, TN; Savannah, GA; Seattle, WA; and Newark, NJ). The CAR program was a partnership between the National Center on Addiction and Substance Abuse at Columbia University (CASA) and the Department of Justice (DOJ) and was funded by agencies under DOJ as well as several foundations and charitable trusts. Based on the findings from the CAR program, CASA received a grant from the Ford Foundation to replicate the CAR model in other neighborhoods. The resulting program is called CASASTART.

CAR was a comprehensive, research-based intervention designed to reach vulnerable children by focusing on small, well-defined neighborhoods characterized by extreme poverty, high crime, and intense social distress. It sought to reduce the overall exposure of youth to crime and drug activity.

CAR focused on 11- to 13-year-old youth attending the middle school served by each of the target neighborhoods. (CASASTART focuses on 8- to 13-year-old children and youths living in impoverished urban neighborhoods.) Eligible youths are identified by program staff – in conjunction with school, police, and court authorities – on the basis of school, family, or personal risk:

- School risk was indicated by such factors as grade retention, special education, poor academic performance, truancy, tardiness, out-of-school suspension, or disruptive behavior.
- Family risk involved family violence or disintegration, family members using drugs or being convicted of crimes, or gang involvement.
- Personal risk was determined by a youth's known or suspected drug activity, being under juvenile court supervision, delinquency or mental illness, membership in a gang or other delinquent peer group, being a victim of abuse or neglect, or being pregnant or already a parent.

CAR and CASASTART programs were developed around a central core of eight required service components:

- Intensive Case Management — Case management was selected as the optimal approach for combining, coordinating, and simplifying access to community resources. Case managers work with only 15 families to ensure that the children's and families' needs are met through a direct intervention or referral to a more appropriate service provider. During the period of program participation, which can be as long as two years, intensive efforts with the clients take place for 3-4 months and are followed by ongoing monitoring, support and crisis intervention.
- Family Services — Family services include, as needed and appropriate, counseling, parenting skills training, stress management/coping skills, and identification and treatment of substance abuse and other health or mental health problems. Referrals are made to education and training programs, job search skills and employment services, and income and social support resources.
- Community-Enhanced Policing/Enhanced Enforcement — All CASASTART and CAR programs include direct participation of police officers as part of the case team. They work one-on-one with children and families and collaborate with case managers on strategies to help individual children and families. They can also perform many other important tasks including being posted on "safe corridors" that children frequent, establishing neighborhood substations, and stepped up supervision and sanctioning of drug offenders to reduce their influence in the neighborhood.
- Criminal/Juvenile Justice Intervention — Case managers work with juvenile court personnel to provide community service opportunities and enhanced supervision of children involved in the juvenile justice system.
- After-School and Summer Activities — All youth are offered recreational programs, life skills/youth development programs, and training or educational opportunities to ensure that their leisure time is spent in positive and productive ways.
- Education Services — Tutoring or homework assistance is available in the program, and remedial or other specialized courses aimed at reducing the chance of academic failure are provided.
- Mentoring — Each program makes arrangements with other local organizations to provide mentors for children in need of caring relationships with adults.
- Incentives — Incentives such as refreshments, gifts, food or product vouchers, and special events are used to build morale and attachment to the pro-social goals of the program. Stipends may also be provided for goal achievement or community service.

Both CAR and CASASTART service packages vary from one site to another. This variation was and is a deliberate effort to increase the sensitivity of the program to the needs of the community and to institutionalize local "ownership" of the program.

Local program planning focuses on developing staff, program content, and special events that are culturally compatible with the neighborhood, built on existing resources, and

address needs identified as high priority by local areas. At the same time, program planners require inclusion of the eight component services in each local program to avoid piecemeal solutions and gaps that could undermine the multifaceted risk reduction strategy.

Risk Factors Addressed

Availability of drugs
Persistent antisocial behavior
Academic failure beginning in elementary school
Friends who engage in the problem behavior

Protective Factors Addressed

Bonding: Peers
Healthy beliefs and clear standards

CSAP Strategy

Alternatives
Problem identification and referral
Community-based processes
Environmental

Type of Strategy

Selective
Indicated

Populations Appropriate for This Best Practice

Youth (ages 8-13) at high risk in urban neighborhoods
African American
Hispanic/Latino

Evaluating This Best Practice

The evaluation tool for this best practice, to be used when implementing this strategy, is not currently being marketed.

The following are suggestions of areas you may want to assess if you implement this promising practice:

- Assess the level of alcohol, tobacco, and other drug use by participants
- Assess participants' attitudes toward ATOD use
- Assess whether participants graduate to the next grade level in school
- Assess positive and negative peer pressure that participants experience

Research Conclusions

(Excerpt from *Impact of the Children At-Risk Program – Comprehensive Final Report II.*)

The Children at Risk evaluation used an experimental design in which children were randomly assigned to either a treatment group (who received the benefit of a safer neighborhood and the intensive services) or a control group (in which they received only the benefit of a safer neighborhood). The CAR evaluation demonstrated that among youth receiving intervention services:

- CAR reduced drug sales and use, reduced the frequency of violence
- Increased the chances of graduating to the next class in school
- Increased positive peer group influences, and
- Decreased peer pressure and peer instigation
- CAR youth were less likely to have sold drugs in the past month or year, or to have used gateway drugs or stronger drugs in the past month, or to have used stronger drugs in the last year, than were youth in the control group
- They were less likely to have friends who were delinquent or who urged them to be antisocial
- They were less likely to feel peer pressure
- They were more likely to feel positive peer support than were youth in the control group

Costs as of December 2001 (Subject to Change)

Training Time:
Once the mental health curriculum is developed, the full training will be six days over a two- to three-month period.

CASASTART training provided by CASA covers the following topics:

- Case management
- Collaboration
- Service integration
- Working successfully with families
- Youth development theory
- Youth mental health assessment

Training is only delivered to community partnerships that are implementing CASASTART.

Training Costs:
Approximately $125,000 per site for a year of training and technical assistance. A unit cost has not been developed as the training is part of the general technical assistance package.

Note: CASA offers a full menu of CASASTART training and technical support services designed to help new sites during their first year of program implementation. Interested agencies and communities should call the contact listed below to discuss how CASA's technical assistance service could be tailored to their communities' needs and resources.

Special Considerations

Please consider the following before selecting this strategy for your community:

- CASASTART is a new way of doing business to help at-risk youth and their families. The CASASTART partnership of community agencies, police departments and schools is complex and difficult to manage because of the different cultures, languages, goals, etc. manifest in each agency.
- Much of the work of managing CASASTART relates to the work of managing the partnership. Agencies that seek to undertake the CASASTART work should have histories of collaboration, be very well regarded by their community and be willing to change the way they do business on behalf of young people and families.

Contact Information

For training, technical assistance, and materials contact:

Lawrence F. Murray, CASA Fellow
The National Center on Addiction and Substance Abuse at Columbia University
633 Third Avenue
New York, NY 10017
E-mail: lmurray@casacolumbia.org
Phone: 212.841.5208
Fax: 212.956.8020

BEST PRACTICE: CEDEN Family Resource Center

Description of Best Practice

(Excerpt from Strengthening America's Families' web site *http://www.strengtheningfamilies.org/index.html*)

CEDEN (Center for Development, Education and Nutrition) provides comprehensive services to promote and strengthen families in need of prenatal, early childhood, and parenting education. The agency's programs seek to improve birth outcomes of pregnant adolescents and at-risk women by providing information to reduce the incidence of premature and low birthweight babies. The agency also provides services to prevent and reverse developmental delays, increase positive parenting behaviors, reduce injuries, and ensure timely immunizations. CEDEN serves primarily low socioeconomic status families and parents with children 0-to-5 years-old who have developmental delays or are at risk of becoming developmentally delayed.

CEDEN's services include an early childhood intervention program for children who are severely delayed, or have a medical condition likely to result in developmental delays. CEDEN's home-based programs accommodate family needs by working with children at child care centers, relatives' homes, shelters for homeless or battered women, and other community shelters. Frequency of home visits is based on family needs, ranging from weekly to monthly visits. Parent educators deliver a series of educational materials including: early childhood stimulation activities, age-appropriate activities, basic health and nutrition care, and home safety, and a Pro-Family Curriculum focusing on child development, behavior, and skill building.

Please note: CEDEN Family Resource Center recently merged with Any Baby Can. The new agency name is Any Baby Can Child and Family Resource Center.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding – families
Skill building

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Children ages 0-5 with developmental delays or at risk of becoming developmentally delayed
- Pregnant adolescents and women at risk and their children
- Low income families

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess increase in family management skills
- Assess improvements in developmental status of children
- Assess increase in family cohesion

Research Conclusions

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html*)

Program evaluations demonstrate CEDEN's effectiveness in improving the developmental status of young children with delays. Children participating in the program maintain up-to-date immunizations at a level higher than average for the community. Parents report great satisfaction in learning and using alternative disciplinary methods. They also feel they understand their children better after participating in CEDEN's programs. Parenting classes and support groups help reduce the social isolation of Spanish speaking mothers by facilitating friendships and boosting self-esteem.

Costs and Special Considerations

Please inquire of the contact listed below.

Contact Information

Please Note: CEDEN Family Resource Center recently merged with Any Baby Can. The new agency name is Any Baby Can Child and Family Resource Center.

Web site: *http://www.abcaus.org*

(The web site contains information on the services to families that they offer. No information on training and technical assistance to replicate their program is currently available on their web site.)

For training, technical assistance, and materials contact:
Terry Arguello and Janet Chapman
Any Baby Can Child and Family Resource Center
1208 East 7th Street
Austin, TX 78702-3223

E-mail: terrya@abcaus.org
janetc@abcaus.org

Phone: 512.477.1130

BEST PRACTICE: Changing the Conditions of Availability

Description of Best Practice

(Excerpts taken from *Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide*, Center for Substance Abuse Prevention, pp. 13-16.)

Alcohol availability is associated with social, civic, and health problems and can be modified through government and community actions. These actions include two distinct dimensions: Controlling outlet density and restricting days and hours of alcohol sales, and restricting availability of alcohol at sporting and recreational events, as well as at special locations such as parks and other publicly owned facilities. While both aspects of this prevention approach are important, substantially more research is needed on the second (i.e., restricting availability at special events and locations).

Lessons Learned

Alcohol consumption levels and the rates of alcohol-related problems tend to increase when a greater density of outlets and increased hours of sale increase the availability of alcohol. Although there is a clear relationship among alcohol outlets, high poverty rates and violence, the location and density of outlets are themselves related to community power. For example, zoning laws often keep liquor stores and high-risk businesses out of affluent neighborhoods.

The following lessons pertain to the regulation of alcohol availability at special events and locations: A wide range of restrictions can be placed on special events, including restrictions on operating hours, noise levels, general location of event, location of alcohol sales or places of consumption (such as beer gardens) advertising of alcohol, alcohol sponsors, age of servers, quantity of sales, size of containers, and condition of the customers. Alcohol sales can be discontinued before an event is over, giving patrons some time between their last drink and driving home. For example, alcohol sales can be discontinued at the end of the third quarter of a football game. Sales of food and nonalcoholic beverages can be required during and after alcohol sales are cut off.

Recommendations for Practice

The following recommendations of the Expert Panel address general issues such as geographic spacing of outlets and community compatibility: Collect data on outlet density, become aware of licensing laws and processes, and consider neighborhood compatibility.

The following Expert Panel recommendations regarding regulations at special events and locations address general issues such as alcohol control activities at community events: Plan ahead, train servers, disseminate rules, use physical visual aids to separate drinking adults from nondrinking ones, educate promoters, and address the need for a balance of interests.

Risk Factors Addressed

Availability of drugs

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

None specifically identified

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the number of alcohol outlets per capita
- Assess the rates of alcohol consumption and alcohol-related problems
- Assess the number of intoxicated persons and the rate of abusive incidents involving intoxication at sporting arenas and special events

Research Conclusions

(Excerpts taken from *Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide*, Center for Substance Abuse Prevention, p. 14.)

The research evidence reviewed indicates that it is possible to implement efforts that result in changes in alcohol availability: There is medium evidence that an increase in the number of outlets per capita increases rates of alcohol consumption and alcohol-related problems. The research and practice evidence reviewed indicates that it is possible to pass legislation regulating the sale and consumption of alcohol at special events and locations. There is suggestive but insufficient evidence that controlling alcohol availability and training servers in sporting arenas and at special events reduces the number of intoxicated persons and the rate of abusive incidents involving intoxication.

Costs and Special Considerations

Not available

Contact Information

For more information on how to implement this best practice:

Order a free copy of CSAP's *Preventing Problems Related to Alcohol Availability: Environmental Approaches*, 1999, order no. "PHD 822, 823 and 825" from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI).

Phone: 800.729.6686, or

Web site: *http://ncadi.samhsa.gov.*

BEST PRACTICE: Changing Hours and Days of Sale

Description of Best Practice

(Excerpts taken from *Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide*, Center for Substance Abuse Prevention, p. 16.)

Governments often influence the availability of alcohol by specifying the hours of sale at specific sites and by allowing sales only on certain days. Although seldom designed for prevention purposes, such changes are natural experiments that provide opportunities to examine the effects on overall alcohol sales and patterns of consumption.

Lessons Learned

- Alcohol consumption levels and rates of alcohol-related problems tend to increase when the hours and days of sale increase.
- Reducing availability is difficult in an era when consumer convenience is such a high priority. Even though one experiment (in Norway) demonstrated clear positive results from Saturday closing, the political support was lacking to continue or extend the closing.

Recommendations for Practice

- Know the law. It's important for communities to be familiar with state and local laws regarding hours and days of operation.
- Be alert for chances to make the case for limited availability. Knowing the law will enable communities to recognize and take advantage of opportunities to exercise control.
- Be alert to seemingly minor or innocuous changes in availability. Proposals to extend hours or days of sale should be evaluated in light of the fact that it is nearly impossible to reverse such changes.

Risk Factors Addressed

Availability of drugs

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

None specifically identified

Evaluating This Best Practice

The following suggestion is an area you may want to assess if you implement this best practice:

- Assess the increase or decrease of the number of hours or days of alcohol sales compared to the rates of alcohol consumption and alcohol-related problems.

Research Conclusions

(Excerpts taken from *Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide*, Center for Substance Abuse Prevention, p. 16.)

The research evidence reviewed indicates that in relation to changes in the days and hours of alcohol sales, there is medium evidence that expanding the hours or days of alcohol sales increases the rates of alcohol consumption and alcohol-related problems.

Costs and Special Considerations

Not available

Contact Information

For more information on how to implement this best practice:

Order a free copy of *CSAP's Preventing Problems Related to Alcohol Availability: Environmental Approaches*, 1999, order no. "PHD 822, 823 and 825" from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI).

Phone: 800.729.6686, or

Web site: *http://ncadi.samhsa.gov*